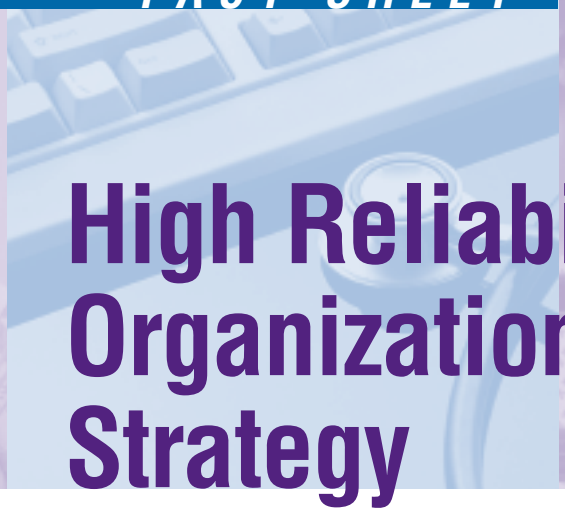

High Reliability Organization (HRO) Strategy

The mission of AHRQ is to improve the quality, safety, efficiency, and effectiveness of health care by:

- Using evidence to improve health care.
- Improving health care outcomes through research.
- Transforming research into practice.

Introduction

Improving health care quality and reducing medical errors continue to be at the top of the Nation's health services research agenda. As the lead Federal agency supporting patient safety research, the Agency for Healthcare Research and Quality is in a unique position to promote a number of initiatives to reach clinicians and other providers with the latest research findings, tools, and practices to improve the quality and safety of health care.

One approach to improving patient safety is the establishment of a learning network with health care leaders who are dedicated to improving patient safety. The goal is to create high reliability organizations; these are organizations that experience fewer than expected medical errors. The purpose of the learning network is to support patient safety leaders in health care systems by providing them with a forum for sharing their experiences, learning about promising practices, and identifying new and innovative ways to implement research findings and promising practices.

What is AHRQ doing?

Establishing a learning network with executives from approximately 8 to 12 health systems to create high reliability organizations. In onsite, Web-based, and audio conferences, executives and researchers will share what they are doing to achieve the goal and how they are using research findings, products, tools, and best practices from AHRQ and others to reduce errors, as well as provide the agency with their priorities for future AHRQ research.

To be a member of the network, each system will agree to implement at least one initiative designed to create a culture conducive to decreasing medical errors and report on initial results after the first year. Initiatives might focus on assessing culture and implementing practices known to improve culture, such as using tools and techniques to improve communication among caregivers.

With whom?

- Selected health care systems that have already made great strides in decreasing medical errors.

- AHRQ's partners include patient safety and knowledge transfer experts and the Center for Healthcare Governance, an American Hospital Association affiliate.

Why?

- Hospitals continue to have safety and quality problems that harm patients and make health care more costly.
- Specific improvements in safety and quality are difficult to sustain if organizational systems and culture are flawed.
- Leaders within organizations striving to become error-free report that they lack a forum where they can learn from each other.
- Innovations that can transform organizations need to be disseminated and adopted more rapidly.

How will AHRQ's resources be used?

- Three face-to-face meetings, ongoing communication by e-mail, LISTSERV®, conference calls, Web events, and possible site visits.
- Technical assistance to help systems develop and measure an implementation plan.

How will we know success?

- Systems will successfully implement interventions that complement their existing patient safety improvement efforts.
- Systems will define and measure outcomes specific to their interventions.
- The learning network will be in place and few, if any, members will drop out.
- Systems with positive outcomes based on knowledge gained from being a network participant will influence other systems and health care providers.
- A strong long-term working relationship will develop between AHRQ and leading patient safety and health care systems.

Synergies with other AHRQ programs

- Sharing of lessons learned from participants in the Patient Safety Improvement Corps when applicable.
- Possible tie-ins to patient safety work underway through the Accelerating Change and Transformation in Organizations and Networks (ACTION) initiative. ACTION promotes innovation in health care delivery by accelerating the development, implementation, dissemination, and uptake of demand-driven and evidence-based products, tools, strategies, and findings.

When will we reassess?

Reassessment will be continuous, since many factors can influence diffusion at multiple points. For example, if participants do not respond favorably to our first meeting, we will follow up to find out how to improve the next meeting to meet their needs. If the first intervention a system tries does not produce the expected initial outcomes, we will work with that system to revise their plan.

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